Patient's Name: _____

Date: _____

Dear _____

Your application for Bayhealth Medical Center Financial Assistance Program is enclosed. Please complete the following items:

Step 1 **Complete both sides of the Financial Application Form.**

Step 2 **Get proof of your income. We require proof of income for a (4) week period ending with the date of your application. This must include income for all dependent members of the family. You may use a payroll check stub, a letter from the employer, a copy of your monthly check you may receive from the government (for example: alimony, child support, unemployment or social security). We will also need copies of your bank statement for the last (3) months and last years Federal and State Tax Return. Patient's who are retired or on disability we require your Current Social Security Benefit notice and your current SSA-1099 Social Security Benefit Statement from Social Security.**

Step 3 **When steps 1 and 2 are completed you can either mail the application or call to set up an appointment to have your application reviewed by either one of our Financial Counselors, their addresses and telephone numbers are as follows:**

Bayhealth Kent Campus
Attn: Financial Counselor Mail Code 1407
640 S. State Street
Dover, Delaware 19901

(302) 744 - 7481

Bayhealth Sussex Campus
Attn: Financial Counselor Mail Code 2109
100 Wellness Way
Milford, Delaware 19963

(302) 430 - 5727

In order for your application to be considered it must be completed, dated, signed and return to the hospital within (30) days of being sent to you.

Sincerely,

Financial Counselor

SURGERY PATIENTS

If you are scheduled, or being scheduled, for surgery it is important you advise us now and do your best to complete and return the application in its entirety to us as soon as possible prior to your surgery.

Surgery Date: _____

Physician Name: _____

Physician Phone Number:_____

Bayhealth

Patient Label

FINANCIAL APPLICATION

Date_____ **SS#**_____

Patient's Name_____ **Date of Birth**_____

Home Address _____ **Phone**_____

Patient's Employer_____**Phone**_____

If Unemployed: How long Unemployed_____ ***Former Employer***_____

Date Became Unemployed_____ ***Are you eligible for COBRA***_____

Employer's Address_____
(If Self Employed Provide Business Address)

Occupation_____**How long Employed**_____

To be Completed by Full Time Students Only:

Are you covered under your parent's, or another insurance policy through the university? _____

If yes, provide policy information:_____

Are your parents claiming you as a dependent on their taxes? _____***Yes*** _ ____***No***

Responsible Party Name_____ **SS#**_____ **Date of Birth**_____

Responsible Party Address_____ **Phone**_____

Spouse's Employer_____**Phone**_____

Spouse's Name_____**SS#**_____ **Date of Birth**_____

Spouse's Employer Address_____ **Phone**_____

Spouse's Occupation_____ **How long Employed**_____

Household Information:

Name(s)	*Relationship to Patient*	*Age*

Total Number of Household Members (including the patient):_____

Bayhealth

FINANCIAL APPLICATION

Patient Label

Monthly Household Income: Give monthly income for yourself and other household members.
Please attach proof of income documents.

Income Category	Self	Spouse and/or Other household members
Wages/Self Employment	$	$
Social Security	$	$
Pension or Retirement Income	$	$
Dividends and Interest	$	$
Rents and Royalties	$	$
Unemployment	$	$
Workers Compensation	$	$
Alimony and Child Support	$	$
Other Income	$	$
Subtotal Monthly Family Income	**$**	**$**

Total Monthly Family Income (add both subtotals together) **$**_____

MONTHLY HOUSEHOLD EXPENSES

Food _____ Elec. _____ Gas _____ Sanitation _____ Phone _____Water _____Cable _____
Child Care _____Auto Ins. _____

Own Home_____Buying ___ Approx. Value _____Mortgage/Rent Payment _____How Long____

Other Property_____ _____Approx. Value _____

Auto #1 _____ Make _____ Year _____Monthly Payment _____

Auto #2 _____ Make _____ Year _____Monthly Payment_____

Recreational Vehicles Own: _____Boat, Motorcycle, Camper, etc._____

INVESTIGATION AUTHORIZATION

I hereby authorize Bayhealth Medical Center or it's agent to investigate any references, statements, or other data made by me or any other person pertaining to my income and financial responsibility. I affirm that the information given on my Financial Application Form is true and correct.

Signature_____ Date _____

OFFICE USE ONLY

Date Application Received_____ Eligible Charges_____

Comments:

Physician Office Response for Surgery: Urgent_____ Semi-Elective_____ Elective_____

Acct. # _____ Amt. _____O/I Acct. # _____Amt. _____ O/I
Acct. # _____ Amt. _____O/I Acct. # _____Amt. _____ O/I
Acct. # _____ Amt. _____O/I Acct. # _____Amt. _____ O/I